Seeking prior authorization (sometimes referred to as pre-authorization, pre-certification, or prior approval) from the patient’s payer for the insertion of a Reveal LINQ™ device for all payers other than traditional Medicare is encouraged. Traditional Medicare does not require, nor does it provide, prior authorization.

The document is not intended as a guide through prior authorization, but rather depicts a simplified version of the prior authorization process for your convenience. The requirements vary by payer. Check with the payer regarding their specific processes. All interactions with private payers should be performed by specially trained personnel.

**DEFINITION**

Prior authorization is approval from a health plan that may be required prior to a service or prescription in order for that service or prescription to be covered by the plan.¹

**FDA-CLEARED INDICATIONS**

The Reveal LINQ device is an implantable, patient-activated, and automatically activated monitoring system that records subcutaneous ECG and is indicated in the following cases:

- Patients with clinical syndromes or situations at increased risk of cardiac arrhythmias
- Patients who experience transient symptoms such as dizziness, palpitation, syncope, and chest pain, that may suggest a cardiac arrhythmia

The device has not been tested specifically for pediatric use.

**DOCUMENTATION**

Documentation in the patient’s medical record should support the medical necessity of all procedures being performed. Some factors to consider including in that documentation might be:

- Any prior incidents, signs, or symptoms that might suggest a history of possible arrhythmia
- Use/type/duration/finding of any prior cardiac monitoring, including any in-hospital cardiac telemetry/monitoring, and/or other prior diagnostic testing
- Any significant risk factors or comorbidities that may affect clinical management
- Any functional impairment that might limit ability to use or activate a monitoring device
- Other alternative diagnostic and/or therapeutic modalities that were considered for this patient but not selected for use
- Potential use and/or impact of the data acquired from the Reveal LINQ device on the clinical management of this patient
**STEPS IN THE PRIOR AUTHORIZATION PROCESS**

**Step 1: Collect Information**
- Collect all patient, physician, and payer information.
  - Patient’s name
  - Insurance ID card/payer information
  - Physician/facility information (NPI and Tax ID numbers)
- Obtain patient consent to release patient information to their insurance company (if required).
- Identify diagnosis and corresponding facility and/or physician billing codes.
- Include documentation supporting the need for the intended procedure or service and any prior testing with results.

**Step 2: Contact the Payer**
- Confirm eligibility and benefits.
- Inquire about coverage for the intended procedure or service.
- Confirm that the service is payable when reported from place of service (POS) 11 (office).
- Determine payer policy requirements for prior authorization. If prior authorization is not required, inquire if a predetermination can be filed.

Verbal authorization may be given based on the information above. Written authorization is preferred. Whether authorization is verbal or written, obtain an authorization number. For written authorization, provide any required prior authorization form(s) for the payer and/or a letter of medical necessity along with supporting documentation and prior testing results.

**Step 3: Send the Requested Information**
Gather all requested materials and mail, fax, or submit online through the payer website to the department responsible for the prior authorization decisions.

**Step 4: Follow-up**
Call the payer to verify receipt of the prior authorization request and continue to follow up routinely with the payer until a coverage decision has been made and communicated back to you.

**Step 5: Re-verify Eligibility**
When the prior authorization has been granted, obtain the prior authorization number and expiration date for your files and request an official approval correspondence. Re-verify the patient’s eligibility to confirm that the patient is still covered by this payer and that the patient’s plan has not changed.

**Step 6: If Necessary, Appeal**
If the prior authorization is denied, the physician and patient must decide if they want to appeal the decision. For an appeal, be prepared to:
- Review the denial and any information provided by the payer. If no information is provided, request information from the payer regarding their appeal process.
- Send an appeal letter and any required materials as directed by the payer.
- Verify the payer received appeal materials.
- File the appeal within the time limit set by the payer as listed in the denial letter.
- Patients can also submit a personal appeal to their payer or contact their employer for assistance.
Disclaimer
Medtronic provides this information for your convenience only. It does not constitute legal advice or a recommendation regarding clinical practice. Information provided is gathered from third-party sources and is subject to change without notice due to frequently changing laws, rules, and regulations. The provider has the responsibility to determine medical necessity and to submit appropriate codes and charges for care provided. Medtronic makes no guarantee that the use of this information will prevent differences of opinion or disputes with Medicare or other payers as to the correct form of billing or the amount that will be paid to providers of service. Please contact your Medicare contractor, other payers, reimbursement specialists, and/or legal counsel for interpretation of coding, coverage, and payment policies. This document provides assistance for FDA-approved or cleared indications. Where reimbursement is sought for use of a product that may be inconsistent with, or not expressly specified in, the FDA-cleared or approved labeling (e.g., instructions for use, operator’s manual, or package insert), consult with your billing advisors or payers on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related service.

References
1 Healthcare.gov glossary available at: https://www.healthcare.gov/glossary/.